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State of Connecticut
REGULATION
of

NAME OF AGENCY

Department of Social Services

Concerning

SUBJECT MATTER OF REGULATION

Physicians' Services

Section 1: Sections 17b-262-337 to 17b-262-349, inclusive, of the Regulations of Connecticut State Agencies, are amended to read as follows:

Sec. 17b-262-337. Scope

Sections 17b-262-337 [through] to 17b-262-349, inclusive, of the Regulations of Connecticut State Agencies, set forth the Department of Social Services requirements for payment of accepted methods of treatment performed by or under the personal supervision of licensed physicians for clients who are determined eligible to receive services under Connecticut's Medicaid Program pursuant to section 17b-261 of the Connecticut General Statutes.

Sec. 17b-262-338. Definitions

[As used in] For the purposes of sections 17b-262-337 [through] to 17b-262-349, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

- (1) "Acute" means symptoms that are severe and have rapid onset and a short course;
- (2) "Admission" means the formal acceptance by a hospital of a client who is to receive health care services while lodged in an area of the hospital reserved for continuous nursing services;
- (3) "Advanced practice registered nurse" means a person licensed pursuant to section 20-94a of the Connecticut General Statutes;
- [(3)] (4) "Allied Health Professional" or "AHP" means a licensed individual other than a physician who [is]: (A) Is qualified by special training, education, skills[,] and experience in health care and treatment [and shall include], (B) is licensed by the Department of Public Health as one or more of the following: [psychologists] Psychologist, licensed clinical social [workers] worker, [nurses] advanced practice registered nurse, nurse-midwife [midwives], physician [assistants] assistant, licensed professional [counselors] counselor, licensed marital and family [therapists] therapist, licensed alcohol and drug [counselors] counselor, physical [therapists] therapist, occupational [therapists] therapist, speech [therapists] pathologist, [audiologists] audiologist, optician, optometrist, [and] respiratory care practitioner or such other category of licensed health care professional that the department permits to enroll individually as a Medicaid provider [practitioners as defined in title 20 of the Connecticut General Statutes], (C) acts within the AHP's scope of practice under state law and (D) complies with all requirements in 42 CFR 440 applicable to the AHP;

- (5) “Audiologist” means a person licensed to practice audiology pursuant to chapter 397a of the Connecticut General Statutes;
- (6) “Billing provider” means a physician, physician group or other entity enrolled in Medicaid that bills the department for physicians’ services;
- [(4)] (7) “Border provider” means a provider located in a state bordering Connecticut, in an area that allows it to generally serve Connecticut residents, and that is enrolled as and treated as a [Connecticut Medical Assistance Program] Medicaid provider. Such providers are certified, accredited[, or licensed by the applicable agency in their state and are deemed border providers by the department on a case-by-case basis;
- [(5)] (8) “Child” means a person who is under twenty-one years of age;
- [(6)] (9) “Chronic disease hospital” [means “chronic disease hospital” as defined] has the same meaning as provided in section [19-13-D1 of the Regulations of Connecticut State Agencies] 19a-550 of the Connecticut General Statutes;
- [(7)] (10) “Client” means a person eligible for goods or services under [the department's] Medicaid [program];
- [(8)] (11) “Commissioner” means the Commissioner of Social Services [appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes];
- [(9)] (12) “Consultation” means those services rendered by a physician whose opinion or advice is requested by the client’s physician or agency in the evaluation or treatment of the client’s illness;
- [(10)] (13) “Department” means the Department of Social Services or its agent;
- [(11)] (14) “Early and Periodic Screening, Diagnostic and Treatment services” or “EPSDT services” means the services provided in accordance with section 1905(r) of the Social Security Act, as amended from time to time;
- [(12)] (15) “Emergency” means an event involving a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity[, (including severe pain)], such that that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention [could reasonably be expected] to result in the following: (A) [placing] Placing the [client’s health] health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (B) serious impairment to bodily functions[, or (C) serious dysfunction of any bodily organ or part;
- [(13)] (16) “Family planning services” means any medically approved diagnostic procedure, treatment, counseling, drug, supply[, or device [which is prescribed or furnished by a provider] that a provider prescribes or furnishes to individuals of childbearing age for the purpose of enabling such individuals to freely plan the number and spacing of their children;
- [(14)] (17) “Fees” means the payments for services, treatments[, and drugs administered by

physicians which [shall be established by the commissioner and contained] the commissioner shall establish and include in the department's fee schedules;

[(15)] (18) "General hospital" [means "general hospital" as defined] has the same meaning as provided in section 17-134d-80 of the Regulations of Connecticut State Agencies;

[(16)] (19) "Home" means the client's place of residence, which includes a boarding home, community living arrangement[, or residential care home. Home does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), or other facilities that are paid an [all inclusive] all-inclusive rate directly by Medicaid for the care of the client;

[(17)] (20) "Hysterectomy" [means "hysterectomy" as defined] has the same meaning as provided in 42 CFR 441.251;

[(18)] (21) "Informed consent" [means "informed consent" as defined] has the same meaning as provided in 42 CFR 441.257;

[(19)] (22) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in [the] Medicaid [program] as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(23) "ICD" means the International Classification of Diseases established by the World Health Organization or such other disease classification system that the department currently requires providers to use when submitting Medicaid claims;

[(20)] (24) "Institutionalized individual" [means an "institutionalized individual" as defined] has the same meaning as provided in 42 CFR 441.251;

[(21)] (25) "Legend Device" [means "legend device" as defined] has the same meaning as provided in section 20-571 of the Connecticut General Statutes;

[(22)] (26) "Legend Drug" [means "legend drug" as defined] has the same meaning as provided in section 20-571 of the Connecticut General Statutes;

(27) "Licensed alcohol and drug counselor" means an individual licensed pursuant to section 20-74s of the Connecticut General Statutes;

(28) "Licensed clinical social worker" has the same meaning as provided in section 20-195m of the Connecticut General Statutes;

(29) "Licensed marital and family therapist" means an individual licensed pursuant to section 20-195c of the Connecticut General Statutes;

(30) "Licensed professional counselor" means an individual licensed pursuant to sections 20-195cc and 20-195dd of the Connecticut General Statutes;

[(23) "Medical appropriateness" or "Medically appropriate" means health care that is provided in

a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;]

- [(24)] (31) “Medicaid” means the program operated by the [Department of Social Services] department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;
- [(25)] (32) “Medical necessity” or “medically necessary” [means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring] has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;
- [(26)] (33) “Medical record” [means “medical record” as defined] has the same meaning as provided in section 19a-14-40 of the Regulations of Connecticut State Agencies;
- [(27)] (34) “Mentally incompetent individual” [means a “mentally incompetent individual” as defined] has the same meaning as provided in 42 CFR 441.251;
- (35) “Nurse-midwife” has the same meaning as provided in section 20-86a of the Connecticut General Statutes;
- [(28)] (36) “Nursing facility” [means a “nursing facility” as defined] has the same meaning as provided in 42 USC 1396r(a);
- (37) “Occupational therapist” has the same meaning as provided in section 20-74a of the Connecticut General Statutes;
- (38) “Optician” means a person licensed pursuant to section 20-146 of the Connecticut General Statutes;
- (39) “Optometrist” has the same meaning as provided in section 20-127 of the Connecticut General Statutes;
- [(29)] (40) [“Out of state”] “Out-of-state provider” means a provider that is located outside Connecticut and is not a border provider;
- [(30)] (41) “Panel or Profile Tests” means [certain multiple] specified groups of tests performed on a single specimen or material derived from the human body [which] that are related to a condition, disorder or family of disorders, [which] and when combined mathematically or otherwise, comprise a finished identifiable laboratory study or studies;
- (42) “Performing provider” means the physician or AHP who actually performs the service;
- (43) “Physical therapist” has the same meaning as provided in section 20-66 of the Connecticut General Statutes;
- [(31)] (44) “Physician” means a person who is: (A) [licensed] Licensed pursuant to section [20-10]

20-13 of the Connecticut General Statutes and (B) acting within the physician's scope of practice under state law;

(45) "Physician assistant" has the same meaning as provided in section 20-12a(5) of the Connecticut General Statutes;

[(32)] (46) "Physicians' services" means services that are billed by the billing provider and are provided;

(A) [by a] By an individual physician [within the scope of practice as defined by state law] who is also the billing provider; [or]

(B) by a physician who is employed by or affiliated with the billing provider; or

(C) by an AHP [within the scope of practice of the AHP as defined by state law] working under the personal supervision of a physician who is employed by or affiliated with the billing provider;

[(33)] (47) "Prior authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;

[(34)] (48) "Provider" means (A) a [licensed] physician or a physician group enrolled in [the] Medicaid [program,] or (B) an AHP [acting within their scope of practice] who is providing physicians' services;

(49) "Psychologist" means a person licensed pursuant to sections 20-188 or 20-190 of the Connecticut General Statutes

[(35)] (50) "Quality of care" means the evaluation of medical care to determine if it meets the professionally recognized standards of acceptable medical care for the client's condition [and the client under treatment];

(51) "Respiratory care practitioner" has the same meaning as provided in section 20-162n of the Connecticut General Statutes;

(52) "Speech pathologist" means a "licensed speech and language pathologist" as defined in section 20-408 of the Connecticut General Statutes;

[(36)] (53) "Sterilization" [means "sterilization" as defined] has the same meaning as provided in 42 CFR 441.251;

[(37)] (54) "Under the personal supervision" means [that the physician shall assume professional responsibility for the service performed by the AHP] the administrative and clinical responsibility personally assumed by the physician for the AHP's services within the AHP's scope of practice;

[(38)] (55) "Usual and customary charge" means the amount that the provider charges for the

service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, “usual and customary charge” [shall be defined as] means the median charge. Token charges for charity patients and other exceptional charges [are to] shall be excluded when calculating the usual and customary charge; and

[(39)] (56) “Utilization review” [means “utilization review” as defined] has the same meaning as provided in section 17-134d-80 of the Regulations of Connecticut State Agencies.

Sec. 17b-262-339. Provider participation

- (a) In order to enroll in Medicaid and for billing providers to receive payment from the department, performing providers and billing providers shall [meet and maintain all departmental enrollment requirements as described in] comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies and shall maintain their enrollment status pursuant to valid provider enrollment agreements on file with the department.
- (b) Performing providers shall enroll in Medicaid as performing providers.
- (c) Billing providers shall enroll in Medicaid as billing providers.

Sec. 17b-262-340. Eligibility

Payment to a billing provider for [a provider’s] physicians’ services billed by the billing provider shall be available on behalf of [all persons eligible for Medicaid] clients who have a need for such services, provided such services are medically necessary, subject to the conditions and limitations that apply to [these] such services.

Sec. 17b-262-341. [Services] Goods and services covered and limitations

The department shall pay billing providers for the following physicians’ services:

- (1) [only for those] Those procedures [listed in the department’s fee schedule for providers] that are medically necessary [and medically appropriate] to treat the client’s condition;
- (2) [for provider] physicians’ services provided in an office, a general hospital, the client’s home, a chronic disease hospital, nursing facility, [icf/mr] ICF/MR or other medical care facility;
- (3) [for] laboratory services provided by a provider in compliance with [the provisions of the Clinical Laboratory Improvement Amendments (CLIA) of 1988] 42 USC 263a to 42 USC 263a-7, inclusive;
- (4) [for] medical and surgical supplies [used by a provider in the course of treatment of a client] for out-of-office use by the client;
- (5) [for] drugs and devices administered by a provider;

- (6) [for] a second opinion for surgery or any other treatment when requested voluntarily by the client or when required by the department. The department shall pay for a second opinion according to the established fees for consultation;
- (7) [for] family planning, abortion and hysterectomy services as described in section 17b-262-348(s) of the Regulations of Connecticut State Agencies;
- (8) [for] Early and Periodic Screening, Diagnostic and Treatment services, including treatment services which are indicated following screening not otherwise covered, provided that prior authorization is obtained;
- (9) [for] surgical services necessary to treat morbid obesity [when] as defined by the ICD that causes or aggravates another medical illness [is caused by, or is aggravated by, the obesity. Such illnesses shall include], including illnesses of the endocrine system or the cardio-pulmonary system, or physical trauma associated with the orthopedic system[. For the purposes of this section, “morbid obesity” means “morbid obesity” as defined by the International Classification of Diseases (ICD), as amended from time to time];
- (10) [for] family planning services for clients of childbearing age, including minors who can be considered sexually active, and who desire the services;
- (11) [for] sterilization for clients who are at least 21 years of age at the time of informed consent; and
- (12) [for] a hysterectomy performed during a period of retroactive eligibility as described in 42 CFR 441.255(e).

Sec. 17b-262-341a. Physician Assistants

- (a) The department shall pay the billing provider for physicians’ services provided by a physician assistant who:
 - (1) Provides services under the personal supervision of a physician;
 - (2) acts within the physician assistant’s scope of practice under state law and performs only functions delegated by the supervising physician in compliance with sections 20-12c and 20-12d of the Connecticut General Statutes and all applicable requirements of the Department of Public Health; and
 - (3) is employed by or affiliated with the billing provider.
- (b) All relevant payment limits described in section 17b-262-348 of the Regulations of Connecticut State Agencies apply to physicians’ services provided by a physician assistant.
- (c) Physician assistants shall enroll individually in Medicaid as performing providers.

Sec. 17b-262-342. [Services] Goods and services not covered

The department shall not pay for the following goods or services or goods or services related to the following:

- (1) [transsexual] Transsexual surgery or for a procedure [which] that is performed as part of the process of preparing an individual for transsexual surgery, such as hormone therapy and electrolysis;
- (2) immunizations, biological products and other products available to providers free of charge;
- (3) examinations and laboratory tests for preventable diseases [which] that are furnished free of charge;
- (4) information or services provided to a client by a provider electronically or over the telephone;
- (5) cosmetic surgery;
- (6) an office visit for the sole purpose of the client obtaining a prescription where the provider previously determined the need for the prescription [has already been determined];
- (7) cancelled services and appointments not kept;
- (8) services provided in a general hospital if the department determines the admission does not, or retrospectively did not, [fit] comply with the department's utilization review requirements [as set forth] in section 17-134d-80 of the Regulations of Connecticut State Agencies;
- (9) infertility treatment;
- (10) sterilizations performed on mentally incompetent individuals or institutionalized individuals;
- (11) more than one visit per day to the same [physician] provider by a client; [and]
- (12) services to treat obesity other than those described in section 17b-262-341(9) of the Regulations of Connecticut State Agencies; and
- (13) any procedures or services of an unproven, educational, social, research, experimental or cosmetic nature; [for] any diagnostic, therapeutic or treatment services in excess of those deemed medically necessary [and medically appropriate] by the department to treat the client's condition; or [for] services not directly related to the client's diagnosis, symptoms or medical history.

Sec. 17b-262-343. Need for service

Payment is available to billing providers for an initial office visit and continuing services [which the department deems] that are medically necessary, [in relation to the diagnosis for which care is required, is available] provided that:

- (a) [the] The services are within the provider's scope of [the provider's] practice;[,] and
- (b) the provider documents the services [are made part of] in the client's medical record.

Sec. 17b-262-344. Prior authorization

- (a) Prior authorization, on forms and in the manner specified by the department, is required in order for payment to be available for the following [provider] physicians' services. Prior authorization is also required for services designated by the department and published on its website or by other means accessible to providers. [:]
- (1) [electrolysis] Electrolysis epilation;
 - (2) physical therapy services in excess of two visits per calendar week per client per provider;
 - (3) physical therapy services in excess of nine visits per calendar year per client per provider, when the therapy being prescribed is for the treatment of:
 - (A) [all] All mental disorders, including diagnoses related to mental retardation and specific delays in development covered by the [International Classification of Diseases (ICD), as amended from time to time] ICD;
 - (B) musculoskeletal system disorders of the spine covered by the ICD[, as amended from time to time]; and
 - (C) symptoms related to nutrition, metabolism[, and development covered by the ICD[, as amended from time to time];
 - (4) reconstructive surgery, including breast reconstruction following mastectomy;
 - (5) plastic surgery;
 - (6) transplant procedures; [and]
 - (7) Early and Periodic Screening, Diagnostic and Treatment services that are identified during a periodic screening as medically necessary and [which] that are not payable pursuant to the [existing] physician fee schedule; and [.]
 - (8) any service or device that is not on the department's fee schedule.
- (b) Prior authorization is required for [payment of] all hospital admissions [as required and described in] pursuant to section 17-134d-80 of the Regulations of Connecticut State Agencies.
- (c) The department shall make payment available to the billing provider only if the provider initiates the authorized procedure or course of treatment [authorized shall be initiated not later] not more than six months [of] after the date of authorization.
- (d) The initial authorization period shall [be for a period] not [to] exceed six months.
- (e) If prior authorization is needed beyond the initial authorization period, the department shall consider requests for continued treatment beyond the initial authorization period [shall be considered] for up to an additional six-month period per request or longer as determined by the department on a case-by-case basis.

- (f) Except in emergency situations, the provider shall receive prior authorization [shall be received] before rendering services [are rendered].
- (g) In an emergency situation involving services that require prior authorization that occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval from the department on the next working day for the services provided. [This applies only to those services that normally require prior authorization.]
- (h) In order to receive payment from the department, a billing provider shall comply with all prior authorization requirements. The department, in its sole discretion, determines what information is necessary in order to approve a prior authorization request. Prior authorization does not[, however,] guarantee payment unless all other requirements for payment are met.

Sec. 17b-262-345. Billing procedures

- (a) [Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include] Billing providers shall submit claims on a hard copy invoice or by electronic transmission to the department in a form and manner specified by the department, together with all information required by the department to process the claim for payment, including, but not limited to identifying the performing provider on each claim.
- (b) The amount billed to the department shall represent the billing provider's usual and customary charge for the services delivered.
- (c) When a client is referred to a provider for consultation, the consultant provider shall include the referring practitioner's name on all applicable claims.
- (d) When billing for anesthesia services, anesthesiologists shall include the name of the primary surgeon on the [bill] claim.
- (e) [Laboratory] The department shall pay the billing provider directly for laboratory services performed in the provider's office [shall be payable to the provider and shall be billed] and the billing provider shall bill the department for such services as separate line items. When a provider refers a client to a private laboratory for services, the laboratory shall bill the department directly and no laboratory charge shall be paid to the provider.
- (f) [when services are provided by] When more than one member of a [group] billing provider provides services, the billing provider shall submit prior authorization [request shall be submitted] requests prior to billing [as described in] in accordance with the billing instructions in the department's provider manual.

Sec. 17b-262-346. Payment

- (a) Fees shall be the same for [in state] in-state, border and out-of-state providers.
- (b) Payment shall be made at the lowest of:
 - (1) [the] The billing provider's usual and customary charge;

- (2) the lowest Medicare rate;
 - (3) the amount in the applicable fee schedule as published by the department pursuant to section 4-67c of the Connecticut General Statutes; or
 - (4) the amount billed by the billing provider.
- (c) Notwithstanding the provisions of the [regulations of connecticut state agencies] Regulations of Connecticut State Agencies or any provisions of the department's Medical Services Policy, the department shall not pay any billing provider under sections 17b-262-337 [through] to 17b-262-349, inclusive, of the Regulations of Connecticut State Agencies for a client seen at a freestanding clinic enrolled in [medicaid] Medicaid. Only the clinic may bill for such services[. As an exception to the foregoing], except that (1) a provider may bill for covered services for a client seen at an outpatient dialysis clinic or at an outpatient surgical facility[. A] and (2) a billing provider [who is] enrolled with Medicaid at a location separate from the clinic may bill the department for clients seen at the separate practice location.
- (d) The department shall not pay interns or residents for their services, nor shall the department pay for assistant surgeons in general hospitals or chronic disease hospitals staffed by interns and residents, unless the procedure is [significantly] sufficiently complicated[, open heart surgery for example, so as to justify] that it is medically necessary for a full surgeon [acting] to act as an assistant, such as for open heart surgery. If the resident or intern performs the surgery [is performed by a resident or intern] and the supervising surgeon assists, the department shall pay only the assistant's fee [shall be paid] to the surgeon[.] and shall not pay the [The] regular surgical fee [shall not be paid].
- (e) If a resident or intern performs the surgery and the supervising surgeon is not present while the procedure is performed, [no fee shall be paid] the department shall not pay any fee to the surgeon even [when] if the surgeon [is] was on call during the surgery.
- (f) When an AHP provides physicians' services, the department shall pay the billing provider that employs or is affiliated with the AHP for such services at the rates applicable to the AHP's provider type, including any percentage adjustment to the physician fee schedule for the AHP's provider type.

Sec. 17b-262-347. Payment rate

The department shall establish and may periodically update the fees for covered [physician] physicians' services [as promulgated] in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

Sec. 17b-262-348. Payment limitations

- (a) The [fees listed in the department's fee schedule shall be payable] department shall pay only [when the] for physicians' services [are] performed by or under the personal supervision of a [provider] physician.
- (b) The department shall pay the fee for an initial visit by a provider in an office, home, ICF/MR or nursing facility only once per client. Initial visits refer to the provider's first contact with the client and reflect higher fees for the additional time required for setting up records and

developing past history. The only exception to this is when the provider-client relationship has been discontinued for three or more years and is then reinstated.

- (c) The department shall pay non-hospital-based providers for evaluation and management services provided to the provider's private practice clients in the emergency room.
- (d) [Payment for physician fees are available] The department shall pay fees to a consultant provider only when another provider or other appropriate referral source requests the opinions and advice of [a physician consultant are requested by another physician or other appropriate source] the consultant provider. The consultant[']s provider must document the provider's opinion and any services [that were] ordered or performed [must be documented] by the provider in the [patient's] client's medical record and [communicated by] submit a written report describing such opinion and services to the requesting physician or other appropriate referral source. [In a consultation, the] The referring provider [carries] remains responsible for carrying out the plan of care after seeking a consultation. [In a referral, a second provider provides direct service to the client.]
- (e) If a client is referred to a provider for treatment of a condition that the referring provider does not usually treat, the department shall pay the treating provider the fee for an office visit rather than the fee for a consultation.
- (f) When the consultant provider assumes the continuing care of the client, the department shall pay the consultant provider for any subsequent service [shall be paid] according to the fee listed for the procedure.
- (g) If a client's medical condition necessitates the concurrent services and skills of two or more providers, the department shall pay each provider [shall be entitled to] the listed fee for the service that [he or she] each provider provides.
- (h) When a provider examines a Medicaid applicant for the purpose of substantiating whether a medical condition exists that would enable the department to determine eligibility for Medicaid disability, the department shall pay the billing provider only for the tests required to establish eligibility as requested by the department. [No] The department shall not pay the billing provider for any other procedures [shall be paid].
- (i) **Surgery**
 - (1) When a billing provider submits a claim [is submitted by a provider] for multiple surgical procedures performed on the same date [of service], the department shall pay the listed fee for the primary surgical procedure [the full Medicaid allowed amount]. [the] The department shall pay for additional surgical procedures performed on that day at 50% of the listed fee [Medicaid allowed amount].
 - (2) When an assistant surgeon, in addition to staff provided by the general hospital or chronic disease hospital, is required, [the amount payable by] the department [to] shall pay the assistant surgeon [shall be] 20% of the listed fee for the surgery.
 - (3) [Fees] The department shall not pay for related evaluation and management encounters on the same day of surgery [are not payable].

- (4) The listed fees for all surgical procedures include the surgery and typical postoperative follow-up care [while in the] provided to clients in a general hospital or chronic disease hospital. [Follow-up] The department shall pay for follow-up visits after a client is discharged from the general hospital or chronic disease hospital [shall be payable] as office visits.
- (5) The listed fees for surgery on the musculoskeletal system [shall include] includes payment for the application of the first cast or traction device.

(j) **Anesthesia**

- (1) The listed fees for anesthesia services include pre- and post-operative visits, the administration of the anesthetic and the administration of fluids and blood incident to the anesthesia or surgery.
- (2) The department shall pay the listed fees for anesthesia services [shall be used] only when the anesthesia is administered by or under the supervision of a [licensed] provider who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia services.
- (3) [No payment shall be made] The department shall not pay for local infiltration or digital block administered by the operating surgeon.

(k) **Radiology**

- (1) The listed fees for all diagnostic radiology procedures, including nuclear medicine, magnetic resonance imaging, computerized axial tomography and diagnostic ultrasound, [shall] include consultation and a written report to the referring provider.
- (2) The listed fees for all diagnostic radiology procedures shall apply only when the provider's own equipment is [being] used. If [the equipment used to perform the procedure is owned directly or indirectly by the] a general hospital or chronic disease hospital or a related entity directly or indirectly owns the equipment used to perform the procedure, or if a hospital includes the operating expenses of the equipment in its cost reports, the department shall not pay the billing provider [shall not be paid] for the technical component of the listed fee.

(l) **Radiotherapy**

- (1) The provider fee for radiological treatment [of malignancies shall include one-year] includes one year of follow-up care unless otherwise specified.
- [(2)] The provider fee for treatment of nonmalignant conditions shall include follow-up care ninety days from the end of treatment unless otherwise specified.]
- [(3)] (2) The provider fee for treatment [shall include] includes the concomitant office visits, but does not include surgical, radiological or laboratory procedures performed on the same day.

[(4)] (3) The fees listed for therapeutic procedures involving the use of radium and radioisotopes [shall] do not include the radioactive drug used or preliminary and follow-up diagnostic tests. Radioactive drugs may be billed separately.

[(5)] (4) The fees listed for diagnostic procedures involving the use of radium and radioisotopes [shall] do not include the radioactive drugs used. Radioactive drugs may be billed separately.

(m) **Laboratory**

- (1) The following routine laboratory tests shall be included in the physician fee for an office visit and shall not be billed on the same date of service: urinalysis without microscopy, hemoglobin determination and urine glucose determination.
- (2) [No payment shall be made] The department shall not pay for tests [which are] provided free of charge.
- (3) [Payment shall be made] The department shall pay for panel or profile tests according to the [fees] listed fees [in the department's fee schedule] for panel tests and not according to the fee for each separate test included in the panel or profile.
- (4) The department shall pay only for laboratory physicians' services that the provider is authorized to perform and are performed in the provider's office. The department shall not pay the referring provider for laboratory services performed in a laboratory or in any setting other than the provider's office.

(n) **Drugs**

- (1) The department shall pay up to the actual acquisition costs for oral medications incident to an office visit as billed by the provider.
- (2) The department shall pay for injectables, legend drugs and legend devices administered by the provider based on a fee schedule determined by the department.
- (3) [No payment shall be made] The department shall not pay for drugs provided free of charge.

(o) **Newborn Care**

- (1) The provider fee for routine care of a normal newborn infant in the general hospital includes history and examination of the infant, initiation of diagnostic and treatment programs, preparation of hospital records, history and physical examination of the baby and conferences with the parents. [Subsequent] The department pays per day for subsequent hospital care for evaluation and management of a normal newborn [is paid per day].
- (2) When a newborn requires other than routine care following delivery, the provider shall bill for the appropriate critical care. The department shall not pay both the critical care and the routine or subsequent newborn care for the same child.

- (3) [Newborn] The provider may bill for newborn resuscitation [may be billed] in addition to billing for routine care or critical care of a newborn [or billing for critical care].

(p) **Payment for assessments and subsequent care for clients in a nursing facility, ICF/MR [and] or chronic disease hospital**

- (1) The department shall [make payments available to] pay providers for evaluation and management only when performed in [the] a nursing facility, ICF/MR or chronic disease hospital.
- (2) The department shall pay for a maximum of one annual assessment [is limited to 1 one] per client per year.

[(q)] **Allergy Procedures**

Providers shall bill for follow-up visits which include intracutaneous tests only if subsequent visits require testing. If follow-up visits do not include testing, regular office visit codes for established clients shall be billed.]

[(r)] (q) **Admission to a General Hospital**

[Payment for services provided by the admitting provider in a general hospital shall not be made available if it is determined by the department's utilization review program,] If the department determines either prospectively or retrospectively pursuant to section 17-134d-80 of the Regulations of Connecticut State Agencies, that [the] a general hospital admission was not medically necessary as defined in section 17b-259b of the Connecticut General Statutes or did not fulfill the accepted professional criteria for [medical necessity, medical appropriateness,] appropriateness of setting or quality of care, the department shall not pay for the admitting provider's services in a general hospital. [Specific requirements are described in section 17-134d-80 of the Regulations of Connecticut State Agencies.]

[(s)] (r) **Family planning, abortion and hysterectomy**

- (1) The department shall pay the provider for sterilization only if the client is at least age 21 and has given [his or her] informed consent in accordance with [the requirements in] 42 CFR 441.250 [through] to 42 CFR 441.259, inclusive, as amended from time to time.
- (2) The department shall pay for hysterectomies and related laboratory and hospital services that are medically necessary [and medically appropriate] only if the client is at least age 21 and the physician or physician's representative has obtained:
- (A) [a] A consent form [in accordance] that complies with 42 CFR 441.251 [through cfr] to 42 CFR 441.259 inclusive, as amended from time to time,
or
- (B) a physician's certification [in accordance] that complies with 42 CFR 441.255(d), as amended from time to time.

- (3) The department shall pay [physicians] the billing provider for all abortions that a physician certifies as medically necessary [and medically appropriate] whether or not the woman's life would be endangered by carrying the fetus to term and whether or not the pregnancy is the result of rape or incest. For the purposes of abortion coverage and payment, a physician determines medical necessity.
- (4) [the] The provider shall maintain all forms required by section 19a-116-1 of the Regulations of Connecticut State Agencies and section 19a-601 of the Connecticut General Statutes.

Sec. 17b-262-349. Documentation and audit requirements

- (a) Providers shall maintain a specific record for all services [received for] provided to each client [eligible for Medicaid payment] including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, [a current treatment plan and] treatment notes signed by the provider, documentation of services provided and the dates the services were provided.
- (b) [All] The provider shall maintain all required documentation [shall be maintained] in its original form for at least five years or longer [by the provider] in accordance with statute or regulation, subject to review by authorized department personnel. In the event of a dispute concerning a service provided, the provider shall maintain the documentation [shall be maintained] until the end of the dispute, five years or the length of time required by statute or regulation, whichever is longest.
- (c) [Failure to maintain all required documentation shall result in the disallowance and recovery by the] The department [of] may disallow and recover any amounts paid to the provider for which the required documentation is not maintained and not provided to the department upon request.
- (d) The department [retains the right to] may audit [any and] all relevant records and documentation and [to] may take any other appropriate quality assurance measures it deems necessary to assure compliance with [these and other] all regulatory and statutory requirements.
- (e) If the provider bills for a service based on the time spent during the encounter, the provider shall document the length of the encounter.

Statement of Purpose

Pursuant to CGS Section 4-170(b)(3), "Each proposed regulation shall have a statement of its purpose following the final section of the regulation." Enter the statement here.

The purpose of the regulations is to add provisions that allow the department to pay for the services of a physician assistant working in conjunction with a physician in accordance with their scope of practice as outlined in Connecticut General Statutes and to enroll PAs individually as Medicaid performing providers.

(A) The problems, issues or circumstances that the regulation proposes to address: Effective January 1, 2012, the department transitioned from a Managed Care Organization ("MCO") model to an Administrative Services Organization ("ASO") model. CMS requires the Department to maintain a certain ratio of primary care practitioners ("PCPs") to clients. PAs working in conjunction with a PCP are included in the count. With the change in management responsibility, the calculation and maintenance of the necessary ratio reverts back to the department and the ASO. Thus, PAs need to enroll as individual providers so the department may determine if the provider network meets federal criteria. Federal statutes and regulations also require Medicaid to enroll all practitioners who are perform, order or refer services for Medicaid clients. To meet this requirement, the department must enroll physician assistants.

(B) The main provisions of the regulation: Add definitions of "physician assistant" and "performing provider" and add a section describing payment of physician assistants. The regulation also makes several technical corrections.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws: The regulation will permit enrollment of physician assistants and payment to their supervising physician for their services. This amendment will also ensure that these providers continue to be available to clients receiving services from a PA paid for by their MCO prior to January 1, 2012 after they are transitioned to the ASO.

CERTIFICATION

This certification statement must be completed in full, including items 3 and 4, if they are applicable.

- 1) I hereby certify that the above (check one) ☒ Regulations ☐ Emergency Regulations
- 2) are (check all that apply) ☐ adopted ☒ amended ☐ repealed by this agency pursuant to the following authority(ies): (complete all that apply)
- a. Connecticut General Statutes section(s) 17b-262.
- b. Public Act Number(s) _____.
(Provide public act number(s) if the act has not yet been codified in the Connecticut General Statutes.)
- 3) And I further certify that notice of intent to adopt, amend or repeal said regulations was published in the **Connecticut Law Journal** on January 17, 2012;
(Insert date of notice publication if publication was required by CGS Section 4-168.)
- 4) And that a public hearing regarding the proposed regulations was held on _____.
(Insert date(s) of public hearing(s) held pursuant to CGS Section 4-168(a)(7), if any, or pursuant to other applicable statute.)
- 5) And that said regulations are **EFFECTIVE** (check one, and complete as applicable)
- ☒ When filed with the Secretary of the State
- OR ☐ on (insert date) _____

| | | |
|--------------------|--|---|
| DATE 11/02/2012 | SIGNED (Head of Board, Agency or Commission) | OFFICIAL TITLE, DULY AUTHORIZED Commissioner |
|--------------------|--|---|

APPROVED by the Attorney General as to legal sufficiency in accordance with CGS Section 4-169, as amended

| | | |
|------|---|---------------------------------|
| DATE | SIGNED (Attorney General or AG's designated representative) | OFFICIAL TITLE, DULY AUTHORIZED |
|------|---|---------------------------------|

Proposed regulations are **DEEMED APPROVED** by the Attorney General in accordance with CGS Section 4-169, as amended, if the attorney General fails to give notice to the agency of any legal insufficiency within thirty (30) days of the receipt of the proposed regulation.

(For Regulation Review Committee Use ONLY)

- ☐ Approved ☐ Rejected without prejudice
- ☐ Approved with technical corrections ☐ Disapproved in part, (Indicate Section Numbers disapproved only)
- ☐ Deemed approved pursuant to CGS Section 4-170(c)

| | | |
|---|------|---|
| By the Legislative Regulation Review Committee in accordance with CGS Section 4-170, as amended | DATE | SIGNED (Administrator, Legislative Regulation Review Committee) |
|---|------|---|

Two certified copies received and filed and one such copy forwarded to the Commission on Official Legal Publications in accordance with CGS Section 4-172, as amended.

| | | |
|------|---------------------------------|----|
| DATE | SIGNED (Secretary of the State) | BY |
|------|---------------------------------|----|

(For Secretary of the State Use ONLY)

GENERAL INSTRUCTIONS

1. All regulations proposed for adoption, amendment or repeal, *except* emergency regulations, must be presented to the Attorney General for his/her determination of legal sufficiency. (See CGS Section 4-169.)
2. After approval by the Attorney General, the original and one electronic copy (in Word format) of all regulations proposed for adoption, amendment or repeal must be presented to the Legislative Regulation Review Committee for its action. (See CGS Sections 4-168 and 4-170 as amended by Public Act 11-150, Sections 18 and 19.)
3. Each proposed regulation section must include the appropriate regulation section number and a section heading. (See CGS Section 4-172.)
4. New language added to an existing regulation must be in underlining or CAPITAL LETTERS, as determined by the Regulation Review Committee. (See CGS 4-170(b).)
5. Existing language to be deleted must be enclosed in brackets []. (See CGS 4-170(b).)
6. A completely new regulation or a new section of an existing regulation must be preceded by the word "(NEW)" in capital letters. (See CGS Section 4-170(b).)
7. The proposed regulation must have a statement of its purpose following the final section of the regulation. (See CGS Section 4-170(b).)
8. The Certification Statement portion of the form must be completed, including all applicable information regarding *Connecticut Law Journal* notice publication date(s) and public hearing(s). (See more specific instructions below.)
9. Additional information regarding rules and procedures of the Legislative Regulation Review Committee can be found on the Committee's web site: <http://www.cga.ct.gov/rr/>.
10. A copy of the Legislative Commissioners' Regulations Drafting Manual is located on the LCO website at http://www.cga.ct.gov/lco/pdfs/Regulations_Drafting_Manual.pdf.

CERTIFICATION STATEMENT INSTRUCTIONS

(Numbers below correspond to the numbered sections of the statement)

1. Indicate whether the regulation is a regular or an emergency regulation adopted under the provisions of CGS Section 4-168(f).
2.
 - a) Indicate whether the regulations contains newly adopted sections, amendments to existing sections, and/or repeals existing sections. Check all cases that apply.
 - b) Indicate the specific legal authority that authorizes or requires adoption, amendment or repeal of the regulation. If the relevant public act has been codified in the most current biennial edition of the *Connecticut General Statutes*, indicate the relevant statute number(s) instead of the public act number. If the public act has not yet been codified, indicate the relevant public act number.
3. Except for emergency regulations adopted under CGS 4-168(f), and technical amendments to an existing regulation adopted under CGS 4-168(g), an agency must publish notice of its intent to adopt a regulation in the *Connecticut Law Journal*. Enter the date of notice publication.
4. CGS Section 4-168(a)(7) prescribes requirements for the holding of an agency public hearing regarding proposed regulations. Enter the date(s) of the hearing(s) held under that section, if any; also enter the date(s) of any hearing(s) the agency was required to hold under the provisions of any other law.
5. As applicable, enter the effective date of the regulation here, or indicate that it is effective upon filing with the Secretary of the State. Please note the information below.

Regulations are effective upon filing with the Secretary of the State or at a later specified date. See CGS Section 4-172(b) which provides that each regulation is effective upon filing, or, if a later date is required by statute or specified in the regulation, the later date is the effective date. An effective date may not precede the effective date of the public act requiring or permitting the regulation. Emergency regulations are effective immediately upon filing with the Secretary of the State, or at a stated date less than twenty days thereafter.